HEALTHY FAMILIES PROGRAM

ELIGIBILITY REQUIREMENTS

The Healthy Families Program provides low-cost health coverage for children, up to age 19, whose family income is between 100-250% of the Federal Income Guidelines. The Program is available to those who meet certain conditions.

- Children must be under age 19
- Children must be California residents
- Family income must be greater than 100% and no greater than 250% of the Federal Income Guidelines (depending on age of child)
- Children can not be eligible for or receiving no-cost Medi-Cal benefits
- Children can not be covered by employer-sponsored health insurance within the previous three months (with some exceptions). See page 5-2
- Children may not be covered by private health insurance
- Children must be U.S. citizens or qualified immigrants

HEALTH, DENTAL, AND VISION BENEFITS

For a small monthly fee called a premium (the premium is as low as $4.00-$9.00 per child per month, up to a maximum of $27.00 for all the children in the family) Healthy Families enrollees will receive a broad benefits package. The benefits package includes:

- Coverage for medically necessary hospitalization
- Physician, medical, and surgical services
- Inpatient and outpatient services
- Immunizations
- Prescription drugs
- Well-child care services
- Family planning services
- Mental health services
- Occupational, physical, and speech therapies
- Laboratory and X-ray services
- Dental benefits, including preventive and diagnostic services
- Vision benefits, including annual exams and eyeglasses

Benefits include preventive health care exams, dental, and vision care that are available for no co-payment. Some services do require a co-payment, which is a small fee that enrollees are required to pay at the time services are received. This co-payment is $5.00 per child, per visit.

EMPLOYER-SPONSORED HEALTH COVERAGE

If a parent cancels employer-sponsored insurance coverage in order to receive Healthy Families, there is a three (3) month period of ineligibility before the children can be covered. A CAA shall not recommend that employer sponsored coverage be dropped in order to apply for Healthy Families.

There are exceptions allowed to this three-month disqualification period. The 3 month waiting period can be waived if the person through whom the employer sponsored coverage has been available either:

- Loses his or her job, or
- Moves to a zip code area that is not covered by the employer-sponsored coverage, or
- Loses health benefits because the person's employer stopped health benefits to all employees, or
- Children were covered under a COBRA policy (insurance coverage for those between jobs) and the COBRA coverage period has ended (the applicant does not have to wait for the COMBRA coverage to expire). COBRA coverage is considered under "Employer-Sponsored" rules. If the parent has declined the COBRA option, there is no three month wait. Like employer sponsored rules, if the parent is covered under a COBRA policy but the child(ren) are not, there is no three month wait, or
- Dies
- Divorces or is legally separated from the parent the child lives with (or applying for the child).

NOTE: These rules do not apply if a child is covered under an individual (privately paid) health, dental or vision policy. Healthy Families Program coverage can begin when private coverage ends.

If children receive medical coverage only through an employer-sponsored plan, they cannot enroll in Healthy Families for dental and vision coverage. However, if only dental or vision is provided by the employer-sponsored plan, they can enroll in Healthy Families.

If it appears you qualify for **Healthy Families** and want to choose your health, dental and vision plan now, fill out this page. Otherwise, we will contact you later for this information. See your **Healthy Families Handbook** for more information, or visit our web site at **www.healthyfamilies.ca.gov.**

SECTION A: Health, Dental and Vision Plan Choices.

54 Health Plan/Code	55 Dental Plan/Code	56 Vision Plan/Code

57 Name of Doctor/Clinic *(optional)*	58 Doctor/Clinic Code *(optional)*	59 Name of Dentist/Clinic *(optional)*	60 Dentist/Clinic Code *(optional)*

SECTION B: Rural Demonstration Project.

61 If you are in any of these groups, there is a new statewide health, dental and vision plan combination offered to you. You can pick this new combination and put the code in the box below. See the **Healthy Families Handbook** for the combination code number.

Check all boxes that apply to you.

❑ Native American Indian **OR** Working in seasonal or migratory jobs: ❑ Agriculture ❑ Forestry ❑ Fishing

Plan Combination Code

SECTION C: Healthy Families Declarations

I declare that each person I am applying for:

- is a resident of California.
- is not in jail or in a mental hospital.
- is not eligible for Medicare Part A and Part B.
- is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s).

I further declare that:

- all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating plans in which the individual is enrolled.
- I have read and understand the **Healthy Families Handbook.** I understand what it says about each health, dental and vision plan and the benefits they offer.
- I am applying for all of my children eligible for **Healthy Families**, unless they are already enrolled, or I am 18 years old or a minor and applying for myself.
- I agree to pay 6 monthly premiums. If I do not pay the premiums, I will be taken off the program and cannot participate again for 6 months. I will have to pay for any **Healthy Families** services I use in the last month after coverage ended.
- I give permission to **Healthy Families** to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this application.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

SECTION D: Privacy Notice.

The Information Practices Act of 1977 and the Federal Privacy Act require the **Healthy Families** Program to provide the following notice to individuals who are asked by **Healthy Families** to supply information:
Personal and medical information requested is for subscriber identification and program administration purposes only. Program regulations under Title 10, CCR, Section 2699.6600 require that every individual furnish certain information when applying to the **Healthy Families** Program. Subscriber's information may be shared with State and local agencies involved in the administration of health programs. Information (including immigration status) about persons who do not become subscribers, will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.
The following information on the application is not mandatory: social security number, ethnicity information (unless the subscriber is a Native American Indian) and any other item marked voluntary or optional. An individual has a right to access records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is the Deputy Director of Eligibility and Enrollment, Managed Risk Medical Insurance Board, 1000 G Street, Room 450, Sacramento, California 95814, (916) 324-4695.

SECTION E: Resolving Disputes.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. The **Healthy Families Handbook** has information about each plan and the arbitration requirements. You may call the plans you choose to find out more.

SECTION F: Signature and Certification.

62 **I certify** that I have read and understand the information above. **I also certify** that the information I have given on this form is true and correct.

Signature _____ Date _____

Witness Signature _____ Date _____
(If person signed with a mark)

MC 321 HFP (rev. 4/00)
APPLICATION

A4

FOR HELP, CALL TOLL-FREE, 1-800-880-5305

CHOICE OF HEALTH, DENTAL AND VISION PLANS, & PROVIDERS GENERAL INFORMATION

On page A4, the applicant will select a health, dental and vision plan.

Refer to the Healthy Families Handbook for information regarding plans by county.

If this page is not completed and the family qualifies for Healthy Families, the enrollment contractor will contact the family to request the completed Healthy Families page and premium. This may delay the enrollment process and the child(ren) will not be enrolled until all information and the premium is received.

The applicant may choose a health, dental and vision plan from the listing in the Healthy Families Handbook. Each health and dental plan has its own providers, dentists, specialists, clinics, laboratories, pharmacies and hospitals. Some plans ask that the family choose a provider. These providers and provider codes are available by calling the Healthy Families enrollment contractor at 1-800-880-5305. If the applicant does not fill in this information on the application page, the plan may assign providers for each child.

Vision Plans: When a child needs vision services, the applicant will call the vision plan. The vision plan will mail an authorization card. The parent will make an appointment and take the card to one of the provider's on the list.

IMPORTANT:

- The applicant must choose the health, dental and vision plans without coaching or guidance from the assistant. Coaching or giving advice on which plans to choose may cause the assistant to lose certification.

- The assistant may help the applicant find information or explain information in the Healthy Families Handbook.

Complete the health plan information on Page A4, following the instructions on this page.

54 Health Plan/Code

List the chosen health plan and its code from the Healthy Families Handbook.

55 Dental Plan/Code

List the chosen dental plan and its code from the Healthy Families Handbook.

56 Vision Plan/Code

List the chosen vision plan and its code from the Healthy Families Handbook.

57 - 60 Provider Names/Codes

If known list the doctor/dentist/clinic and their codes in these boxes. Refer to the Healthy Families website to get provider codes.

61 RURAL DEMONSTRATION PROJECT

This plan is available to Native American Indians and families working in seasonal or migratory jobs such as agriculture, forestry and fishing. The plan information, Combination Code and premium information is provided in the Healthy Families Handbook. This plan allows families to move throughout the state without changing health plans.

If the applicant has chosen the Rural Demonstration Project, as described above, check all boxes that apply to indicate if the applicant is:

- A Native American Indian
- Working in seasonal/migratory agriculture
- Working in seasonal/migratory forestry
- Working in seasonal/migratory fishing

Enter the Plan Combination Code (in the Healthy Families Handbook) if the Rural Demonstration Project is chosen.

SECTION C: HEALTHY FAMILIES DECLARATIONS

The assistant should call the applicant's attention to the Healthy Families Declarations listed on Page 7 of the application. The declarations are listed below with clarifying comments as needed.

1. Applicant declares that the child(ren) live in California. Children must be California residents to be eligible for Healthy Families.
2. Applicant declares that the child(ren) is not in jail or a patient in a public mental illness hospital. This is related to the financial obligation of a public institution for health care.
3. Applicant declares that the person on the application is not eligible for Medicare, Part A and Part B. This means the child is disabled for at least two years and may receive Social Security payments through the parent. Children *eligible for* Medicare Part A and Part B are not eligible for Healthy Families.
4. Applicant declares that the child(ren) are not eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s). Examples of employment situations where these benefits are available include Federal, State or County employees, school district employees. Children *eligible for* health benefits from California PERS are not eligible for Healthy Families.
5. Applicant declares he or she will follow all the rules of the Healthy Families program, as stated in the Healthy Families Handbook.
6. Applicant has read and understands the Healthy Families Handbook. The handbook contains important information about eligibility, premium, and other program details.
7. Applicant declares that the children meet all the requirements of Healthy Families.
8. Applicant agrees to pay the family monthly premium at least six months.
9. Applicant gives permission to the Healthy Families program to verify information given in the application.
10. Applicant agrees to tell the Healthy Families program when there is a change of address. Healthy Families must have the applicant's current address to mail the monthly bill for the premium, as well as other important program information.

SECTION D: PRIVACY NOTICE

The information in this section gives an explanation about how information on the application will be used by the Healthy Families program. The CAA should review this section with the applicant.

SECTION E: RESOLVING DISPUTES

Some plans require all disagreements (coverage questions, denials of service and medical malpractice claims) to be sent to arbitration. Others allow the patient to file a court action for medical malpractice, but require other types of disagreements to be arbitrated. *Arbitration is an out-of-court process for settling disagreements.*

Refer to the Healthy Families Handbook "Answers to commonly asked questions…" to identify plans that require Binding Arbitration.

SECTION F: SIGNATURE

The *applicant* signs and dates this section. The signature certifies that all information is true and correct.

MONTHLY PREMIUM INSTRUCTIONS

Use the following instructions to determine the monthly premium for Healthy Families.

1. Refer to the worksheet process from Chapter 4
   - Find the number of family members listed on the HF Income Calculation worksheet
   - Find the net family income amount listed on the HF Income Calculation worksheet
2. Use the chart below to determine if the family's net income is in Category A or B
   - Look under the number of family members in the household
   - Determine which Income Category (A or B) the family's net income is in

3. In the Healthy Families Handbook, look up the county where the children live and the health plan the applicant has chosen.
4. Under "Insurance Premium" is the monthly premium the family will pay (depending on the number of children to be on Healthy Families and their Income Category)

April 1, 2002 to March 31, 2003

Family Size # of Persons	Category A Monthly Income	Category B Monthly Income
1	$750 - $1,123	$1,123.01 - $1,871
2	$1,011 - 1,515	$1,515.01 - $2,525
3	$1,273 - $1,908	$1,908.01 - $3,180
4	$1,535 - $2,300	$2,300.01 - $3,834
5	$1,796 - $2,693	$2,693.01 - $4,488
6	$2,058 - $3,085	$3,085.01 - $5,142
7	$2,320 - $3,478	$3,478.01 - $5,796
8	$2,581 - $3,870	$3,870.01 - $6,450
9	$2,843 - $4,263	$4,263.01 - $7,105
10	$3,105 - $4,655	$4,655.01 - $7,759
	For more than 10 persons, add amount below for each additional child	
	$263 – $393	$394 – $655

This chart is updated on April 1st every year.

FIRST MONTH'S PREMIUM

A personal check, cashier's check or money order, payable to Healthy Families Program, can be submitted with the application. If the first month's premium payment is not submitted with the application, the Healthy Families enrollment contractor will contact the applicant to request payment. The child(ren) will **NOT** be enrolled in Healthy Families until the premium is received.

After the first payment, the applicant can make the other payments with a credit card, an electronic fund transfer, or at a Rite Aid pay station.

SAVE MONEY ON REMAINING PREMIUMS

THERE ARE TWO WAYS TO SAVE ON PREMIUM AMOUNTS:

- Healthy Families offers an advantage to making three months of payments at one time. If the applicant pays for three months of Healthy Families at one time, he or she will get the fourth month FREE. For more information, call the Healthy Families Enrollment Contractor at 1-800-880-5305.
- Families who pay their premiums by Electronic Funds Transfer (EFT) will receive a 25% discount on their monthly premium. The authorization form to begin the EFT process is on the back of the billing invoice sent to the applicant each month.

IMPORTANT: If the family appears to be eligible for and wants Healthy Families, they should complete page A4 and submit premium payments. Getting this payment after the application is received by Healthy Families or not selecting a health, vision, dental plan will only delay the date Healthy Families coverage will begin for the child.

Note: If submitting Native American Indian or Alaska Native documents with application, no premium payment is required.

CAA REMINDER

- The Enrollment Entity/Certified Application Assistant should NEVER accept any premium payments or handle any money on behalf of the applicant.
- Premium payment should be attached to the application and mailed by the applicant.

HEALTHY FAMILIES REVIEW FORM/APPEAL PROCESS

To appeal a Healthy Families decision families may use the "Review Form" which is mailed with their denial letter (shown on page 5-9). This form is also available by calling the Healthy Families Information line. CAA's may help applicants when completing this form, but Healthy Families will contact the applicant with the results of the review.

Healthy Families Program
Review Form

Applicant Information:

Family Member Number:

Name	First:	Last:	
Phone Number	Day Hours: ( ) -	Evening Hours : ( ) -	
Mailing Address	Street:		Apt. No.
	City:	State:	Zip Code:

Child(ren)'s Information:

Child's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Child's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Child's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Child's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Child's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Child's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -

Reason(s) for Review (You must respond to numbers 1 through 4; number 5 is optional. Please attach a separate piece of paper if you need more space to write.):

1) Please tell us the decision you would like us to review. (Or, you may include a copy of the letter you received from the Healthy Families Program that indicates the decision you want reviewed.)

2) Please tell us why you disagree with our decision. (You may check one or more boxes below, or explain in writing.)

- ☐ Disagree with income calculations
- ☐ Disagree that a payment was not made
- ☐ Other (explain in writing):
- ☐ Did submit birth certificate(s)
- ☐ Did submit immigration document(s)
- ☐ Child is not on no-cost Medi-Cal

3A) Do you think our decision violated a law, rule, regulation, or program policy that is printed in the Healthy Families Program application, handbook, or other program materials? ☐ yes ☐ no

3B) If "yes," which one?

4) Please tell us what action you would like us to take.

5) Please tell us if there is any other information you think would help us in reviewing our decision. (You may attach supporting documentation.)

Applicant's Signature:	**Date:**

☐ **Please check if documentation is attached. Please write your Family Member Number on each document.**

Please mail or fax this form to:

Healthy Families Program
Attn: Review Unit
P.O. Box 138005
Sacramento, CA 95813-8005
Fax: (916) 859-2359

For Use By Healthy Families Program Review Only	
Research Analyst Name:	
Date Received:	Date Completed:

Rev 07/24/00 Tx #21

EARLY ENROLLMENT PROCESS

An applicant may apply for the Healthy Families Program for children who are not yet eligible at the time of the application, but who might become eligible within three months after completing the application. The situations when this may occur are:

- A child will become 1 year old and lose no-cost Medi-Cal
- A child will become 6 years old and lose no-cost Medi-Cal
- A child's no-cost Medi-Cal is ending
- An unborn child with a net household income between 200% - 250% of the Federal Income Guidelines

Families who are applying for an unborn child should provide as much information as known about the unborn child in Section 2 of the application in the "Child 1 or Unborn" column Questions 22, 27, and 28. The applicant must also provide pregnancy verification which includes the estimated date of delivery to pre-enroll an unborn child.

In order for coverage to begin after the child's birth the applicant must provide one of the following:

- A birth certificate provided by a hospital or other heath care facility, OR
- A signed statement by the health practitioner who presided over the delivery, OR
- an equivalent document.

The documentation must include the child's name, place and date of birth, gender, and date released from the hospital. Healthy Families must receive the documentation within 30 days of the child's birth or the applicant will have to submit a new application. Health coverage for a newborn will begin 13 days after Healthy Families receives the documentation of the child's birth.

HEALTHY FAMILIES OPEN ENROLLMENT (OE)

Each year, between April 15 and May 31, families with children enrolled in Healthy Families will have an opportunity to choose a new health, dental and vision plan for their children. It may also be necessary to choose a new health, dental and vision plan if the one(s) they currently have are no longer available. Healthy Families will mail an open enrollment package to the family with pre-printed information about the plans available and premium payments. Plan changes will be effective July 1st. It is very important that the family notify Healthy Families of their new address whenever the family moves.

HEALTHY FAMILIES ANNUAL ELIGIBILITY REVIEW (AER)

The Healthy Families Program requires an annual eligibility review every 12 months. The anniversary date is based upon the last enrollment date of a child in the household.

Sixty days prior to the anniversary date the family will receive an annual eligibility review (AER) packet. The family size and income of the household will be evaluated. Documentation of income is required. A separate form will be included in the packet, to be used if the family has a child to add into the existing Healthy Families case. If a family wants to enroll another child at a time other than AER, they would complete an "Add A Person" form. There is NO reimbursement for assistance provided to add a child or adult using the " Add A Person" form. (DO NOT fill out a new application to add a person to an existing case, as it will be viewed as fraud by single Point of Entry).

HEALTHY FAMILIES ANNUAL ELIGIBILITY REVIEW (AER) (continued)

If during AER the family income drops to where they no longer qualify for Healthy Families, they will be disenrolled and their packet will be forwarded to the County Department of Social Services. It is important that the applicant sign the "authorization to forward" section on the AER application.

If a CAA helps a family complete the AER form, they can request a $25 reimbursement. The AER form must be correctly and completely filled out in order for the EE to receive reimbursement. Like the complete application, the CAA must record their name, nine-digit CAA number, and 5-digit EE number to be reimbursed (proposed elimination of reimbursements, effective 6/30/03).

If the AER packet is not completed and returned, the children will be disenrolled. However, they will not have to wait before re-applying.

Note: Only an original family specific "Annual Eligibility Review" form will be accepted.

BRIDGING BETWEEN THE HEALTHY FAMILIES AND MEDI–CAL PROGRAMS

HFP TO MEDI - CAL BRIDGING COVERAGE

Beginning with families who received their AER packages in July 2002 (with September 2002 anniversary month) and whose children are determined to be below the HFP income, an additional two months of coverage under the HFP will be granted. This additional coverage is called the HFP Bridging coverage. During the HFP Bridging coverage, the application and all supporting documentation will be forwarded to the County Welfare Department (CWD) for a no-cost Medi-Cal determination, if the applicant provided authorization. If the applicant did not provide authorization, the HFP Bridging coverage will still be granted and the applicant will be sent a "Reconsider Medi-Cal" letter. If this form is returned, HFP will forward the application and all supporting documentation to the CWD. In order to continue the HFP coverage, the applicant must continue to pay their premiums during the bridging months. Disenrollment from the HFP will be effective two months after the end of the month of the subscriber's anniversary date for those covered in the HFP Bridge.

MEDI - CAL TO HFP BRIDGING COVERAGE

During the annual determination process, families whose income is deemed higher than the upper limit for no-cost Medi-Cal will receive one month of additional coverage under the Medi-Cal program while a determination is made regarding their eligibility for the Healthy Families Program. This is known as Medi-Cal Bridging coverage. During this process, the application and supporting documents will be forwarded to the Single Point of Entry (SPE) for a Healthy Families Program determination, if the applicant has provided authorization for the referral to be made.

DISENROLLMENTS

The chart below lists reasons for disenrollment from Healthy Families, as well as re-enrollment eligibility, if applicable.

CHILD WILL BE DISENROLLED IF:	CHILD CAN BE RE-ENROLLED WHEN:
Annual Eligibility Review Packet is not returned by the end of the month of the anniversary date.	Either using the pre-printed AER form or a new application is completed, reviewed, and approved. Applicant may submit the AER form for up to 60 days after disenrollment.
Found to be ineligible during the Annual Eligibility Review.	Reason for ineligibility has changed, if applicable.
Reaches the age of 19.	Not applicable.
Premium is not paid for 60 days after the payment due date.	Pay premiums past due at time of disenrollment •Parent or applicant suffered a catastrophic illness that resulted in being unable to work for 2 weeks, or •Person responsible for the premium payment lost a job, or •Child became eligible for no-cost Medi-Cal.
Applicant requests disenrollment in writing from Healthy Families.	Applicant re-applies

If the parent/applicant disagrees with a disenrollment decision, the process to appeal is described in the Healthy Families handbook.

HEALTHY FAMILIES QUALIFIED IMMIGRANTS

Following is a list of qualified immigrant statuses that qualify a child for the Healthy Families Program.

Changes in California State law make it possible for the Healthy Families Program to enroll recent legal immigrant children who entered the U.S. on or after August 22, 1996. Children must meet all other program eligibility criteria. If a child is otherwise eligible for the program, not having proof of the entry date before August 22, 1996, will not disqualify them. An INS document with the date of entry must be submitted. The change in State law affects the following immigration statuses:

- Lawfully Admitted Permanent Residents
- An alien granted conditional entry
- An alien parolled into the U.S.
- An alien with the appropriate immigrations status who has been battered or subjected to extreme cruelty.

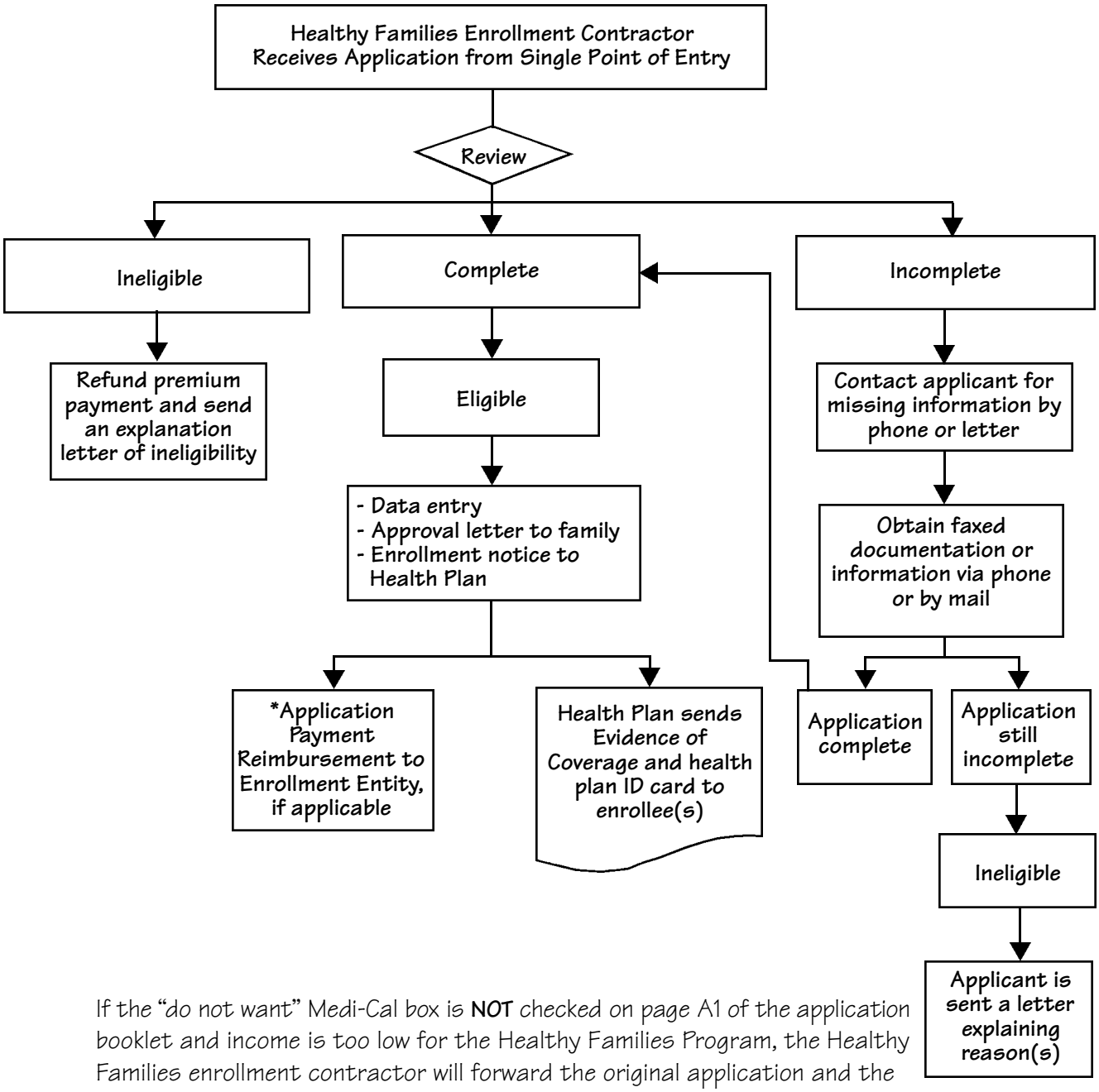
Children in the above categories with a date of entry before August 22, 1996 are not affected by this law change and will continue to be eligible for the Program for as long as they continue to become eligible.

The following group of immigrants do not have restrictions on the date of entry:

- An alien granted asylum
- A refugee admitted to the U.S.
- An alien whose deportation is being withheld
- An alien who is a Cuban or Haitian entrant
- Qualified aliens lawfully residing in any state who are honorably discharged veterans
- The spouse, unmarried dependent or unmarried surviving spouse
- An Amerasian immigrant

For information on which documents can be used to verify immigration status, the applicant should refer to the Citizenship and Immigration Information section of the Healthy Families Handbook.

Note: Additional Information on regulations can be found in the citizenship-immigration section of the Healthy Families Handbook.



If the "do not want" Medi-Cal box is **NOT** checked on page A1 of the application booklet and income is too low for the Healthy Families Program, the Healthy Families enrollment contractor will forward the original application and the supporting documents to the county Department of Social Services in the county where the applicant lives.

* Application assistance reimbursement section (9) must be accurately and completely filled out (proposed elimination of reimbursements, effective 6/30/03).

ADD A PERSON FORM

SECTION 1

1 Applicant Name	Home Phone	Work Phone	Message Phone

2 Family Member Number

Please fill out this form for any person you would like to add to Healthy Families. To add more than 4 people, make a photocopy of this form. If a pregnant woman is within 90 days of her expected delivery date, she may apply to add her unborn child to Healthy Families. Coverage for the unborn child will begin 13 days after Healthy Families receives documentation of the baby's birth.

SECTION 2	Person 1 (or unborn)	Person 2	Person 3	Person 4
3 Name: Last				
First				
Middle				
4 Birthname: Last				
(If same as #3 above, leave blank) First				
Middle				
5 If the person's address is NOT the same as the Applicant, give address	Street City ZIP	Street City ZIP	Street City ZIP	Street City ZIP
6 Relationship to Applicant:				
7 Sex:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
8 Date of Birth (or estimated date of delivery)	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR
9 Place of Birth: **Calif. County, State or Country**				
10 Ethnicity Code				

1	White	2	Hispanic	3	Black/African American	4	Asian
5a	American Indian	5b	Alaska Native	7	Filipino	A	Amerasian
C	Chinese	H	Cambodian	J	Japanese	M	Samoan
N	Asian Indian	P	Hawaiian	R	Guamanian	T	Laotian
V	Vietnamese	K	Korean	Z	Other		

11 U.S. Citizen or National? If no, please write date of entry into U.S.	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR
12 Social Security # (optional)	- -	- -	- -	- -
13 Mother's Name: Last				
(required for children) First				
Does the mother live in the home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14 Father's Name: Last				
(for children) First				
Does the father live in the home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

HF FM ST (EN) (rev. 03/1/02)

SECTION 2 CONTINUED	Person 1 (or unborn)	Person 2	Person 3	Person 4
15 Does this person have no-cost Medi-Cal? If yes, give date coverage will end.	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR
16 Does the person have any health care coverage? If "yes," what kind?	☐ Yes ☐ No ☐ Health ☐ Vision ☐ Dental	☐ Yes ☐ No ☐ Health ☐ Vision ☐ Dental	☐ Yes ☐ No ☐ Health ☐ Vision ☐ Dental	☐ Yes ☐ No ☐ Health ☐ Vision ☐ Dental
17 Was the person insured by an employer in the last 90 days? If yes, check the main reason why insurance stopped and give the date it stopped.	☐ Yes ☐ No ☐ Lost job or changed job status ☐ Moved and no insurance available ☐ Employer ended benefits to all employees or certain categories of employees ☐ COBRA coverage ended ☐ Death, legal separation, or divorce ☐ Other ________ ________ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost job or changed job status ☐ Moved and no insurance available ☐ Employer ended benefits to all employees or certain categories of employees ☐ COBRA coverage ended ☐ Death, legal separation, or divorce ☐ Other ________ ________ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost job or changed job status ☐ Moved and no insurance available ☐ Employer ended benefits to all employees or certain categories of employees ☐ COBRA coverage ended ☐ Death, legal separation, or divorce ☐ Other ________ ________ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost job or changed job status ☐ Moved and no insurance available ☐ Employer ended benefits to all employees or certain categories of employees ☐ COBRA coverage ended ☐ Death, legal separation, or divorce ☐ Other ________ ________ / / MO DAY YEAR
18 **SECTION 3** Monthly Countable Income *(if any)*	$ From where?	$ From where?	$ From where?	$ From where?

19 Gross (before taxes) monthly countable income of the applicant and the other adult in the household.	Applicant $________ From where? Relationship to person(s):	How often Received? ☐ Once every week ☐ Every two weeks ☐ Twice a month ☐ Every month	Other Adult $________ From where? Relationship to person(s):	How often Received? ☐ Once every week ☐ Every two weeks ☐ Twice a month ☐ Every month

20 Monthly Income Deductions (For each working parent, we will deduct up to $90 for work related expenses)		
	Monthly childcare expenses you pay for children under age 2. The maximum amount allowed is $200	$
	Monthly childcare expenses you pay for children age 2 and over. The maximum amount allowed is $175	$
	Monthly disabled dependent care expenses you pay. The maximum amount allowed is $175	$
	Monthly court ordered alimony/spousal support you pay.	$
	Monthly court ordered child support you pay	$

21 Is the applicant or anyone else in the home pregnant?	☐ Yes ☐ No **If Yes, please list name** ________________

- **See the *Household Information Instructions* for a list of what income counts and acceptable income documentation.**
- **You must include a birth certificate for each person you want to add who is a U.S. citizen or national (within 60 days) and documentation of birth for a newborn (within 30 days of birth) or;**
- **Proof of immigration status for each person you want to add (within 30 days)**

I, the applicant, certify that the information provided is true and correct. I understand that adding additional family members may result in a higher monthly premium.

Applicant Signature X________________________ **Date:**____________

22 **Authorization to Forward to Medi-Cal**

If this person/child is ineligible for Healthy Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of persons/children applying for full scope Medi-Cal benefits. **Applicant Signature X**________________________ **Date:**____________